IN THE CIRCUIT COURT OF OHIO COUNTY, WEST VIRGINIA

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In Re: Tobacco Litigation (Medical Monitoring Cases)	Civil Action No. 00-C-6000
	(Judge Arthur M. Recht)
	(Judge Tod J. Kaufman)

- - - -

DEPOSITION OF: GEORGE ALAN YEASTED, M.D.

- - - -

DATE: September 7, 2000
Thursday, 2:00 p.m.

LOCATION: Holiday Inn Pittsburgh South
164 Fort Couch Road
Pittsburgh, PA

TAKEN BY: Plaintiffs

REPORTED BY: Beth E. Welsh
Notary Public
AKF Reference No. BW61025

DEPOSITION OF GEORGE ALAN YEASTED, M.D., a witness, called by the Plaintiffs for examination, taken by and before Beth E. Welsh, a Court Reporter and Notary Public in and for the Commonwealth of Pennsylvania, at the Holiday Inn Pittsburgh South, 164 Fort Couch Road, Pittsburgh, Pennsylvania, on Thursday, September 7, 2000, commencing at 2:05 p.m.

- - - -

APPEARANCES:

FOR THE PLAINTIFFS:

David P. Chervenick, Esq.
GOLDBERG PERSKY JENNINGS & WHITE
1030 Fifth Avenue
Pittsburgh, PA 15219
412-471-3980

FOR THE DEFENDANT RJ REYNOLDS TOBACCO COMPANY:

Susan Davis Crooks, Esq.
Stephanie T. Perry, Ph.D., Esq.
WOMBLE CARLYLE SANDRIDGE & RICE
Suite 2100
150 Fayetteville Street Mall
Post Office Box 831
Raleigh, NC 27602
919-755-2113

(The following attorneys began to participate via telephone):

FOR THE DEFENDANT BROWN & WILLIAMSON:

Mary Jo Middelhoff, Esq.
DINSMORE & SHOHL
1900 Chemed Center
255 East Fifth Street
Cincinnati, OH 45202
513-977-8622

FOR THE DEFENDANT LORILLARD TOBACCO COMPANY:

Meredith Perkins, Esq.
THOMPSON COBURN
One Firstar Plaza
Suite 2700
St. Louis, MO 63101
314-552-6322

FOR THE DEFENDANT BROWN & WILLIAMSON:

Rob Aliff, Esq.
JACKSON & KELLY PLLC
1600 Laidley Tower
500 East Lee Street
Charleston, WV 25301
304-340-1286

FOR THE DEFENDANT LORILLARD TOBACCO COMPANY:

Susan Morton, Esq.
914 Fifth Avenue
Huntington, WV 25701
304-522-9100

FOR THE DEFENDANT RJ REYNOLDS TOBACCO COMPANY:

Corey Palumbo, Esq.
BOWLES RICE McDAVID GRAFF & LOVE
600 Quarrier Street
Charleston, WV 25301
304-347-1781

* I N D E X *

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GEORGE ALAN YEASTED, M.D.,
having been duly sworn,
was examined and testified as follows:

- - - -

EXAMINATION

- - - -

BY MR. CHERVENICK:

Q. Doctor Yeasted, my name is Dave Chervenick, and I represent the plaintiffs in an action that we filed in West Virginia, and the reason that we're here today I'm going to be asking you some questions today about your role and your testimony and about an Expert Witness Disclosure that I was provided. If you don't understand any of my questions or want me to repeat a question, just ask me to do so or tell me you don't understand and I'll make it understandable for you.

A. Okay.

Q. I have a copy of your CV which is attached to the Expert Witness Disclosure and I just want to ask you about a few things on here. You're still with MLDC Internal Medicine Associates on Cedar Boulevard?

A. That's correct. We have two offices though,

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and I'm actually located at the other office.

Q. Which office are you located at?

A. At the Bethel Park office.

Q. Is that the one --

A. 1300 Oxford Drive, Suite 2B, I believe it's on there.

Q. That's the new UPMC medical facility over here kind of across the street from where we are today?

A. That's correct.

Q. How long have you been with that office, the MLDC?

A. 23 years.

Q. I want to ask you a few questions about your CV. It indicates that from 1986 through 1989 you were a regional representative slash lobbyist for the Pennsylvania Society of Internal Medicine.

A. That's correct.

Q. Can you tell me what you did in that role?

A. Not a lot. What we had to do occasionally if there was a matter of interest to the internal medicine physicians I know at one time I was asked to go to Washington and speak with at

that time Senator Heinz, but it wasn't with

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Senator Heinz, it was with one of his aids, about an issue, I think it was an issue related to Medicare.

Q. You were lobbying on behalf of the Pennsylvania Society of Internal Medicine?

A. That's correct. Actually, I think to be more correct at the time I was a member of both the Pennsylvania Society of Internal Medicine and of course then the American Society, and I believe it was the American Society of Internal Medicine asked for people from each state to go to Washington, so I'm not sure to be specific to your answer whether I was really for Pennsylvania or for the national organization.

Q. Okay. How many times did you go to Washington?

A. One time. That was the only time.

Q. Under positions and appointments I just can't read it at the top it says medical examiner 1995 to present, it looks like Amoco Corp.?

A. It's Amoco, they have a facility on the South Side of Pittsburgh and when they need to have examinations done for their employees they'll call.

Q. Is that the one down off of Carson Street towards Streets Run Road?

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A. Yes.

Q. And your role is to examine their employees?

A. Yes.

Q. Under what circumstances do you perform the examinations?

A. There would be probably two, one would be if there were probably more of an executive type of an employee that got a corporate yearly examination, there also -- there's probably three, I should say three, there were also examinations that were done if someone worked in a field which was considered what we would call in medicine a hazardous waste field or they were exposed to some chemical substances and they were required to have examinations, we would do those, and then I know there were cases over the years where someone were sick or minor injury at work, not a major injury because you'd go to the emergency room, but a minor injury they would ask us to take a look at them if their arm were sore or something of that nature.

Q. What kind of chemical waste or hazardous substances are they exposed to down there that would cause people to get evaluated by you?

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A. Honestly I can't give you a specific answer of what they are exposed to at this point I mean other than the oil, you know.

Q. Right. Gasoline?

A. Yeah. I mean I don't know of any specific chemicals I could give you right now.

Q. Are these pre-employment checks or are they periodic checks during their employment?

A. Both.

FEMALE VOICE: Is everyone still on?
FEMALE VOICE: Yes.
FEMALE VOICE: I was just making sure, I heard it click off.
MS. CROOKS: Someone may have joined us.
MR. CHERVENICK: Is there anybody new on the line that has not given your name to the court reporter?

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(Pause without response.)

- - - -

BY MR. CHERVENICK:

Q. The people that work for Amoco that come to you, are you looking for any particular diseases or problems in them?

A. Not any particular other than general I think, general examinations like we do for anybody.
Q. It says that you're a medical director for Consolidated Enterprises from 1980 to the present and they're located at 3000 Industrial Boulevard?
A. They have moved.
Q. Where are they located now?
A. It's now called Centimark. I don't know their new address, but I know where it is. It's near the -- hang on. That would be in Cecil Township, South Pointe Exit, where the South Pointe complex is.
Q. South Pointe Exit off 79?
A. Yes.
Q. What kind of business is that?
A. It's a roofing business. They may have other -- roofing is what they're known for.
Q. What do you do for them?
A. That's different. That's their executives that are sent in for corporate examinations.
Q. I take it they're not exposed to anything in particular?
A. Not the people that I examine.
Q. You're just doing a general medical exam --

A. Yes.
Q. -- that is commonly referred to or I guess you doctors would commonly refer to as a general physical?
A. Yes.
Q. It looks like the hospitals at which you have admitting privileges are St. Clair, Montefiore and Presbyterian University Hospital?
A. That's correct.
Q. Are there any in addition to that?
A. No, only those three.
Q. I want to ask you some questions about your involvement in this case. Can you tell me how you came to be contacted by lawyers for the cigarette industry to testify in this case?
A. I was contacted by an attorney in Pittsburgh who asked if I would be willing to -- I'll start again, somebody was saying something.
THE COURT REPORTER: Could you not hear the doctor?

FEMALE VOICE: No, I haven't heard a word.
MALE VOICE: If the deposition has been ongoing, the people on the phone haven't heard anything.

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THE COURT REPORTER: We've been going since five after 2.
MALE VOICE: We've heard no questions and no answers.
FEMALE VOICE: As soon as we heard the court reporter swear the witness then it went sort of blank.

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(There was a discussion off the record, and there was a pause in the proceedings.)

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MR. CHERVENICK: It's approximately 3:05 and we've been trying for the better part of an hour to get a better phone, we moved conference rooms from a conference room to a regular hotel room, took out the bed, put a table in, went through a couple of phones in this room, we were unable to solve the problem. As a result there is nobody on the telephone attending this deposition even though people intended to attend the deposition by phone.
On behalf of plaintiffs I'm waiving any requirement that local counsel be present at this deposition for defense. I am licensed

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in West Virginia, don't have a problem, but we're waiving that role for the purposes of this deposition, and we apologize to those folks on the phone, but the choice was either cut them off the phone or resume this deposition at another date because of these difficulties.
MS. CROOKS: And all objections would be reserved for the people who are unable to attend?
MR. CHERVENICK: Right.

BY MR. CHERVENICK:

Q. Ready?
A. Are you going to repeat your question?
Q. Yes.
A. Good, it's been a long time.
Q. I think what I asked you, Doctor, was how did you become to be involved in this case?
A. I was contacted by an attorney in Pittsburgh who had gotten my name from another attorney in his firm that I knew just as a personal friend, and he asked if I would be willing to testify in a case in West Virginia and would I be willing to look at records. And I said that I would, and he asked me to come into town and

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discuss the case.
Q. Do you know who the attorney was that asked you to get involved?
A. Joe Federowicz.
Q. Was he the friend or was he the other person?

A. No, he was the attorney.
Q. What office is he with?
A. I believe it's Dickie McCamey.
Q. Did you then go to his office and discuss this case with him?
A. Yes.
Q. Do you know when you were contacted by Mr. Federowicz?
A. Not exactly. Maybe July if this is September.
Q. July of this year?
A. Oh, yes, I'm sorry, July of 2000.
Q. How many meetings did you have with him?
A. Just one.
Q. Was anyone else present at that meeting?
A. Yes, two attorneys, one was Ms. Stephanie Perry and the other was Chris Olson, I think it's O-L-S-O-N, they were from out of town.
Q. Was that at the meeting at Dickie McCamey?
A. Yes.
Q. How long did you meet with them on that occasion?

A. I don't remember. I would say at least an hour.
Q. When was that meeting?
A. That was the one that you asked me earlier, I think it was in July. I mean I could probably figure out the date because I do recall it was the day I took my daughter to school. So if I could find out when she went to John Carroll, then I could figure it out.
Q. So you think you were contacted in July and you also met with Mr. Federowicz in July?
A. I believe that was the case. I mean I'm sure that it was not long after he contacted me that we had the meeting, so I would assume it was in the same month. It could have been right at the end of the month and at the beginning of another.
Q. Okay. How many meetings did you have with attorneys for this case?
A. I'd have to look at my records to answer you honestly.
Q. Can you just approximate for me, was it less than ten?
A. It felt like more than ten. It might have been about ten. It wasn't five, I mean it was more than that.

Q. More than five?
A. Oh, yeah. Ten sounds about correct, but I'd have to actually check the records to see.
Q. Okay.
A. I kept a record.
Q. Somewhere around ten, it could be more, it could be less?
A. Yes, including the first visit.
Q. Who did you meet with on the other occasions?
A. Generally with Ms. Perry, occasionally with Ms. Crooks and occasionally with Attorney Andrew Wattleworth, I think it's W-A-T-T-L-E-W-O-R-T-H.
Q. Was any one attorney present at all the

different meetings?
A. If anyone was, it would be Ms. Perry. I'm not certain that I could answer that she was there every time, but if there was one person always there, it would be Ms. Perry.
Q. Where were those meetings held, these subsequent meetings after the one at Dickie McCamey?
A. I would think that they were -- I think they

were all in my office, but I would say the majority of them were in my office in Bethel Park.
Q. Did you have any meetings at attorney's offices after Mr. Federowicz's?
A. I don't believe so.
Q. How long did the meetings last approximately on each occasion?
A. Approximately two to three hours.
Q. Were you shown materials during these meetings by the attorneys?
A. Occasionally I'd be shown materials.
Q. What kind of materials did you review with the attorneys?
A. I reviewed articles from journals, textbook information, medical records, oh, I'm sorry, I saw the Complaint in the case and one of the reports of Doctor Burns, I saw a report of Doctor Burns.
Q. Do you know which one it was?
A. It just listed a revised report. I believe it was dated February 3rd of 2000, but don't hold me to the date, but it was something like that.
Q. Did you see a report called report of Doctor Burns?

A. I think the only one I saw was called revised report of Doctor Burns.
Q. Okay. Did you see any reports from any other plaintiffs' experts?
A. I don't think so, no.
Q. Did you review any transcripts of any testimony of any physicians either plaintiff or defense?
A. On my own or with attorneys?
Q. Take it with the attorneys first.
A. No.
Q. How about on your own, did they give you some depositions --
A. Doctor Burns' testimony, the deposition I think that would be called.
Q. Do you know which transcript it was, what the date was on it?
A. I don't remember.
Q. Was it April of this year?
A. I believe it was, but I'm not positive. There were two volumes, there were two different days that I remember.
Q. Okay. Did you, in fact, review both of those volumes?
A. Yes.
Q. Prior to today did you meet with attorneys in

preparation for your deposition this week?

A. This week? Prior to today, this is Thursday, I don't think so. No. No, this was Labor Day week, no.
Q. Did you meet with anybody last week?
A. I believe last Thursday.
Q. Where was that meeting held?
A. In my office.
Q. Who was present at that meeting?
A. Stephanie Perry was. Susan, I think you were present, but I'm not positive. I remember those two. Hang on a second. If I have my dates and times correct, there was another attorney there, but I will tell you honestly I don't know her name, it was a lady.
Q. How long did that meeting last?
A. Last week?
Q. Yes, sir.
A. I'd have to check my records, but I believe that meeting lasted approximately four hours.
Q. Did you review any materials at that meeting?
A. What's your definition of review materials? I could answer you better if I knew what you were referring to.
Q. Go over any journal articles, let's start with

that, did you review any journal articles?
A. Yeah, we would discuss articles. They might, for example, say did you read the article such and such, and I would answer yes, I read it.
Q. Were these articles that they had provided you with previously?
A. The articles last week I believe the answer would be yes.
Q. How many articles have you been provided by the attorneys for the cigarette companies?
A. I didn't count them, so if you want an estimate, I can answer your question.
Q. An estimate is fine.
A. It seemed to me maybe ten, eleven, something of that nature.
Q. Do you know the names of the articles that you were given by the attorneys?
A. Some I do.
Q. Could you give me the names of them?
A. Sure. There was a -- I don't know if this is the actual name, but I'll give you what it was about.
Q. Okay.
A. The American College of Cardiology and American Heart Association had a review about the use of

exercise stress testing to discover disease in asymptomatic people, so the title was I think A Guideline by the American Heart Association and American College of Cardiology. There was a Mayo Clinic study that I reviewed.
Q. Was that on the use of screening techniques to detect lung cancer?
A. Yes. There was a preventative services guideline from the U.S. Government that again would be screening techniques and screening procedures. There were national -- I don't know the titles here, but I could tell you what

they were. There would be, for example, news reports from the National Cancer Institute or the American College of -- I didn't mean to say that, the American Cancer Society, the American Cancer Society or the National Cancer Institute would have like a news brief that would touch on a subject that we already mentioned use of screening techniques for certain diseases.
Q. Did you see an article as well that would accompany the news release from the NCI?
A. Sometimes.
Q. Sometimes?
A. Sometimes. Some of the more recent ones I would say no. I think there was one in August of 2000 I think, just a few months ago, last month in fact.

Q. What was that one about, do you remember?
A. Not off the top of my head, I could look and see.
Q. These reports I'll call them even though they were journal articles and news releases, but I'll lump them under the term reports, have you seen any of those previously, I mean in your own --
A. I understand your question. The problem is you read a lot of journals as a doctor, and I'm not sure -- you might have seen it, but not remembered that it was the Mayo Clinic study. So I knew the information in the articles almost all the time. I, for example, had not seen the American College of Cardiology monograph that I was given, but I knew all the information in it because of conferences we go to and the work we do every day.
Q. In these meetings would you discuss your opinions on these papers that you had been shown?
A. Uh-huh, oftentimes.

Q. Were you asked whether you agreed with the position of the papers or the position taken in the papers rather?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Which papers do you mean?
Q. Any of these papers that you were being given.
A. If you give me a specific question, I could answer it.
Q. Let's say the Mayo Clinic paper on screening, were you, for instance, asked what your opinion was on the issue?
A. I think the answer would actually be more is this what you would do in your practice because I was asked to -- when I was asked by Mr. Federowicz in the beginning it was as an internist and what I do in my practice. So I think it was more is this what you would do in your practice.
Q. Okay.
A. Not so much my opinion on what the experts said because that was a different situation.
Q. Did any of the articles that you were given

contradict what you do in your practice?
MS. CROOKS: I object to the form.

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BY MR. CHERVENICK:
Q. You can answer.
A. Do you mean any --
Q. Any articles that you reviewed that you were given by the attorneys and asked to review and then discuss in the meeting?
A. No, I don't think so.
MS. CROOKS: I'm going to object.
THE WITNESS: I'm sorry.
MS. CROOKS: That's a very broad question over many, many articles that have many, many things. If you have specific questions about things in the articles --
BY MR. CHERVENICK:
A. That would be easier to answer, yes, for me.
Q. Okay. Can you estimate for me the amount of time that you spent meeting with the various attorneys?
A. I could estimate the amount -- if you would like this answer, I could estimate the amount of time I spent reviewing information and meeting with attorneys, I have it more in my head that way. I'd have to separate it out.
Q. Okay, when you say that let me just make sure you're talking about on your own and in your

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meetings with attorneys?
A. Yes.
Q. You can give me that, that's fine.
A. In July I know it was about nine hours, including that first meeting with Mr. Federowicz. In August it was about I think just over fifteen hours as I recall.
Q. Did you meet today prior to the deposition?
A. Yes.
Q. How long was that meeting?
A. One and a half hours.
Q. Was that the only time spent so far in the month of September? I guess last Thursday would be August 31st.
A. Yeah.
Q. So today's meeting would be the first meeting anyway in September?
A. In a meeting, yes.
Q. Did you do any --
A. In a meeting, that's correct.
Q. Did you do any preparation on your own in the month of September?
A. Well, today I read for an hour this morning before I met with the attorneys.
Q. Can you tell me the rate that you're charging

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the attorneys for your review and testimony?
A. $200 per hour.
Q. Does that include the deposition and review of documents?
A. Yes.
Q. Does that money go to you or does it go to MLDC?
A. No, that money goes to the individual.

Q. It goes to you?
A. Uh-huh.
Q. Have you written any reports in this case?
A. No, I have not.
Q. Have you been asked to write any reports?
A. I have not.
Q. Now, you indicated that some of the material that you reviewed included medical records. Was that the medical records of the represented plaintiffs in this case?
A. There were two, yes.
Q. Blankenship, was that one of them?
A. Yes, it was.
Q. When did you review the medical records?
A. Do you mean in the course of which month, is that what you're asking me?
Q. Yes.

A. I would think -- again, by memory I would say probably in July.
Q. Was that for both individuals?
A. Yes.
Q. How much time would you estimate you spent reviewing the medical records of the two represented plaintiffs?
A. I didn't work it out that way, but possibly total going through the records possibly maybe three hours.
Q. Have you ever testified before today in a deposition?
A. In a deposition, yes. Once in a -- well, once in a deposition regarding a patient of my own. This was many years ago, probably more than fifteen years ago, I don't even remember the case. It was a patient that I think was in an accident and the deposition involved an attorney coming to my office with a court reporter and asking me to go through the medical records with them to determine what the health of the person was prior to the accident.
Q. Okay.
A. And then I went to a deposition with a court reporter that wasn't going to be a court case,

but was going to be I guess a mediator or an arbitrator case, and it was a case where I was asked to look at medical records of a person that was in an accident who was not my patient.
Q. Did one of the attorneys in the case ask you to look at the medical records or was it the arbitrator?
A. No, one of the attorneys in the case of the accident. The first case I think it was just an attorney for the patient probably, I don't remember.
Q. The person who asked you to look at the records, was it the attorney for the person who was injured or was it the defense lawyer?
A. No, it was the defense lawyer.
Q. Did you testify in that deposition?
A. The second -- no neither actually, the answer would be no. I gave a deposition, is that what you mean?

Q. Right.
A. I gave a deposition, but it didn't go to court. This wasn't a court case, it was an arbitrator case, and I just had to give a deposition to be presented.
Q. How long ago was that second one that you

talked about?
A. That was in the year 2000.
Q. Do you know who the defense lawyer was?
A. The attorney that asked me to look at the case?
Q. Yes, sir.
A. Peter Skeel.
Q. Do you remember who the other lawyer was, the plaintiff's lawyer?
A. Yes, I do.
Q. Who was that?
A. Robert Peirce. There must be a father and sone, it was the son.
Q. Not the former commissioner?
A. Right. That's who I thought I was going to see when I went.

MR. CHERVENICK: Off the record.

- - - -

(There was a discussion off the record.)

- - - -

BY MR. CHERVENICK:
Q. Do you know Peter Skeel away from work?
A. He's my neighbor. That's why he asked me to do it, he said would you look at a case for me, I said all right.
Q. I had your home address.

A. That's how it happened. I never did any work for him, but he was my neighbor and he said will you look at the case and I said all right.
Q. I know where he lives, on that hill coming down towards the Galleria?
A. We both live there.
Q. Any other depositions other than those two that we just discussed?
A. I think that's the only depositions I ever gave where there was a court reporter.
Q. How about have you ever testified in court?
A. I've testified twice.
Q. Can you tell me a little bit about those, let's start with the first time?
A. I don't know the year, it was a good while ago. It was in Armstrong County, it was a medical malpractice case I would say in a sense, although quite sincerely it was more a case of -- do you know what a 302 deposition is? It's a commitment, a 302 commitment, it was a physician who had signed a 302 commitment for a patient who felt that she was unjustifiably kept against her will in a hospital. That was the case that I had to review and make a decision as to whether the doctor acted in the

best interest of the patient and had appropriate medical background to do so.
Q. Who asked you to get involved in that case?
A. Paula Koczan.

Q. Is that a lawyer?
A. Yes, I'm sorry.
Q. Is that the lawyer for the --
A. For the doctor.
Q. For the doctor?
A. Uh-huh.
Q. The testimony was in a courtroom in Armstrong County?
A. Is that Kittanning?
Q. I think so.
A. Yeah.
Q. How about the second time that you testified in court?
A. I remember where it was, that was in Greensburg. I'm trying to think what the case was, hang on. Give me a second, I'll think of the case in a minute. Oh, I do remember, it was a case -- I apologize, I know who testified in front of me and I know the name of the attorney and I can't think of what the general nature of the case was.

Q. Do you know if it was a medical malpractice case?
A. Yes, it was. I know there was a neurosurgeon in front of me testifying and the attorney was Stephen Dalesio.
Q. Were you asked by an attorney for one side or the other to give an opinion on the case?
A. Yes.
Q. Was it the plaintiff's lawyer or the defense lawyer?
A. That would have been the defense lawyer.
Q. Were those the only two occasions on which you've testified in court?
A. Yes.
Q. I want to show you what I'm going to ask to be marked as Exhibit A. It's titled Expert Witness Disclosure. It's got your name on it and it's multi-page, but it's only two pages and then one sentence on the opinion part and the rest I believe is your CV.
A. Okay.

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(Deposition Exhibit A marked for identification, and the witness reviewed the document.)

- - - -

BY MR. CHERVENICK:
Q. Was the information on here in the first couple pages provided by you to the lawyers for the cigarette companies?
A. We discussed it before it was written.
Q. Can you tell me what it was that you discussed? I guess what I'm asking is were you presented with this document or something like this and asked for your input or were you starting from a clean slate and you just discussed things and this became the result?
A. I think we discussed things, this became the result and then the second part would be that I reviewed it and agreed to what was in it.

Q. Did somebody in your office type this up?
A. No, sir.
Q. Do you know if it was somebody at the offices of one of the attorneys for the cigarette companies?
A. I don't know who typed it.
Q. Did you prepare a rough draft of this in any way in your own handwriting?
A. No, it was all verbal.
Q. Did you review the document before it was sent

out by the lawyers?
A. Yes, I did.
Q. Do you have any changes that you wish to make in it?
A. Do I have any changes?
Q. Yes, sir.
A. No. I reviewed it before it was typed.
Q. Okay. It's stated in here that you'll testify or you'll speak -- I'm in the second sentence under subject matter, you'll speak to the propriety of the proposed medical monitoring program set forth in the revised report of Doctor David M. Burns and any medical monitoring program proposed by plaintiffs. Is that based on your review of Doctor Burns' revised report that we talked about a couple minutes ago?
A. Well, the comment on the part of the sentence that reads the revised report of Doctor David Burns the answer would be yes.
Q. Okay. Do you recall what medical monitoring programs were set forth by Doctor Burns that you disagree with?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:

A. Which particular ones did you want me to comment on?
Q. Any of his proposals that you disagree with.
MS. CROOKS: Are you talking about in the revised report?
MR. CHERVENICK: Right.
MS. CROOKS: Do you want to see the revised report?
BY MR. CHERVENICK:
A. Yeah, could I see it please and I could go over it more carefully with you as we go, it's easier that way.
Q. (Handing document.)
A. Thanks.

- - - -

(The witness reviewed the document.)

- - - -

BY MR. CHERVENICK:
A. This isn't dated, so I don't know that this is exactly the same one that I had. I'd have to go through this because I'm not sure it's the same one.
Q. Do you want to take a few minutes and just go through it and satisfy yourself that it's the same?

MS. CROOKS: I object. I don't know how he can satisfy himself that it's the same without comparing them.
MR. CHERVENICK: Okay.
BY MR. CHERVENICK:
A. The one I saw was signed and dated.
- - - -
(The witness reviewed the document.)
- - - -
BY MR. CHERVENICK:
A. I don't know if this is exactly the same as I saw, but I can comment on what's on this report. Is that what you would like me to do?
Q. I can do it an easier way.
A. Okay.
Q. Let me just ask you some general questions first. In your opinion are cigarettes dangerous?
A. Dangerous in what way?
MS. CROOKS: I object to the extent that it calls for a legal conclusion.
BY MR. CHERVENICK:
Q. Dangerous in a medical sense, not a legal sense.
A. It would depend on, you know, how much, how

often, level of exposure essentially.
Q. Are you saying that if cigarettes are consumed below a certain level and below a certain rate that they're safe?
A. I would say that if consumed below a certain level and a certain rate that statistically the risk would not be significant.
Q. Apart from statistics and significance of statistics, I'm just asking you in general do you think that there's any rate and level at which cigarettes are safe?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. It seems like the same question. I think that there is -- again, there's probably a level of consumption or -- not consumption, that's not a good term, let's say exposure, there's a level of exposure that probably is statistically not significant at all.
Q. What's that level in your opinion?
A. That's not determined, no one knows.
Q. Do you think cigarettes are addictive?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. It depends on your definition of addictive.

Q. How do you define addictive?
A. Addictive depending on the substance that you're discussing would mean that someone feels the need to use that substance, whether physical or psychological.
Q. In your opinion using that definition are cigarettes addictive?
A. Using that definition? Again, if that's my definition of addictive, they could be addictive because psychological is already in my definition.

Q. Is it the nicotine in the cigarettes that make them addictive?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. That, I don't know. Not being an expert on addiction I really don't know the answer to your question.
Q. Do cigarettes cause disease?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Again, it's the same kind of question. You'd have to determine what you mean by cigarettes in level of exposure and what you mean by disease.

Q. In general at any level does cigarette smoking cause disease?
A. It goes back to the original answer, again, level of exposure and what disease you're talking about.
Q. Well, I'm not a physician. Do you counsel your own patients on quitting cigarette smoking if one of your patients is a cigarette smoker?
A. Yes, I do.
Q. What do you tell them about the diseases cigarettes can cause?
MS. CROOKS: I object to the form.
THE WITNESS: Should I answer the question?
MS. CROOKS: If you can answer it.
BY MR. CHERVENICK:
A. Could you please repeat it because I lost my train of thought?
Q. When you counsel your own patients who are smokers what diseases do you relate to them that cigarettes cause?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Okay, I understand the question. Probably in the majority of times -- it's a condition where

I think at this point in time, sir, you don't really do that as much anymore, you just say -- they know what they've heard, they know the surgeon general's warning and probably I emphasize it more than anything else, and I'm not honestly sure that I give them a specific disease or what to watch for, you just say, look, you know you have to quit smoking, you know it causes problems, they know.
Q. Well, what problems does it cause?
A. Well --
Q. You're presuming that I know or a lay person knows, but as a physician with a medical background I just want you to tell me what diseases you know to be caused by cigarette smoking.
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. When I counsel patients, which was the original question, my counseling that particular person, which we do on an individual basis, would in many ways be determined by what their medical

condition and what I know about their history and their family history is. That's why it's a difficult question to answer because if I knew

that someone had a specific problem in addition to cigarette smoking, then we would emphasize that problem also. It's all part of the general discussion with the patient on how you get them to change their lifestyle.

Q. Does cigarette smoking cause lung cancer?

MS. CROOKS: I object to the form.

BY MR. CHERVENICK:

A. There's a statistical increase in lung cancer in smokers versus non-smokers, the cause and effect relationship I do not know.

Q. Do you know what the percentage is of smokers who contract lung cancer?

A. I don't know the exact number, but I believe it's fewer than ten percent.

Q. Do you know the percentage of people with lung cancer that smoke?

A. Again, don't hold me to the actual number, but I believe if you look at it that way it's approximately 80 percent. It depends on the type of lung cancer too. You'd have to define your terms because some lung cancers would not be very often associated with smoking and some types -- we call them cell types, I'm sure you're familiar with that, some cell types

would be a higher percentage associated with smoking than non-smoking, but some are not. It depends on the type of cancer.

Q. Do you know what the percentage is of non-smokers who contract lung cancer?

A. I do not know that percentage. Again, you'd have to define cancer because it would be a different percentage. Lung cancer is a large term that would not be the same for every type of tumor, there would be different numbers for different types of lung cancers.

Q. What types of tumors in your opinion are associated with cigarette smoking, what cell types?

A. The small cell carcinoma which we sometimes call oat cell and also squamous cell.

Q. What percentage of small cell or oat cell cancers occur in smokers?

A. I don't know the answer to that question.

Q. The same question with respect to squamous cell?

A. I don't know how to break it down personally.

Q. At what rate in your opinion is there a statistically increased incidence of lung cancer in smokers? I guess that depends on --

A. Level of exposure.

Q. What level?

A. We are taught in our training and we pass this on to the medical students and residents that we train that approximately twenty-pack years, that's a statistically increased risk of disease from cigarette smoking.

Q. In your opinion is there an increased risk for contracting lung cancer at ten-pack years?
A. I wish I could answer your question. I don't know the actual number to answer you honestly. I know that twenty is a number that we're taught in our training, a twenty-pack year history makes it significant, statistically significant.
Q. Is it your opinion that smoking at a rate less than twenty-pack years is a safe level?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I don't have an opinion on that. I mean one would have to assume that there is a risk over -- again, what number -- you used ten in your question?
Q. I used ten.
A. Ten over nine possibly, but what happens is

that it may be a very slow increase in percentage risk until you reach twenty-pack years and at that point the risk becomes significant, that's why that number is chosen in the teaching programs.
Q. Do you counsel people to stop smoking if they have smoked let's say for five-pack years?
A. I would counsel them, sure.
Q. Why would you counsel them to quit?
A. So they wouldn't get to twenty-pack years.
Q. Do you know if there's an increased risk, not statistically significant, but any increased risk at any pack year level less than twenty-pack years?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. It's a difficult question for us to answer because we deal with statistically significant risks, that's why I can't really answer your question. It would require a general opinion that any lay person would give, it's not a medical opinion. We go with statistically significant increases.
Q. What is the statistically significant increase at twenty-pack years for contracting lung

cancer over someone who is not a smoker?
A. Let me see if I can get the answer for you, hang on. Over a non-smoker? I don't know if I have that number in my head. I actually don't know the answer to that without checking it.
Q. Do you know what the statistically increased risk is for a twenty-pack year smoker over a smoker who has smoked less than twenty-pack years?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Not a number. I know what the curve looks like, that's what I recall in our training. You have a sharp rise in the curve. I don't know the actual like two to one, four to one, that type of thing, if that's what you're asking, I don't know the answer to that question.

Q. In your opinion can smoking-related disease occur in people who smoke less than twenty-pack years?

MS. CROOKS: I object to the form.

BY MR. CHERVENICK:

A. There are a couple problems to that question. What's a smoking-related disease? It's a

disease that --

Q. Let's say lung cancer.

A. Well, of course lung cancer can occur in non-smokers so, you know, that's why I said the question is difficult because the disease that a person who smokes gets can be the same disease that a person who doesn't smoke gets. So of course anyone can get any disease.

Q. Is there a statistically increased risk of getting a small cell or oat cell cancer in somebody who is a twenty -- let's say somebody who is a ten-pack year smoker over someone who is a non-smoker?

A. Did you ask me --

MS. CROOKS: I object to the form.

BY MR. CHERVENICK:

A. I have to ask a question because I didn't hear the whole question. Did you say is there an increased or a statistically significant increase?

Q. I think I said statistically increased risk of getting small cell or oat cell cancer in a ten-pack year smoker over a non-smoker?

A. I would think there is, again, not statistically significant, a statistical

increase, probably a statistical increase, yes, to answer your question.

Q. Can you quantify that?

A. No. Again, it's the curve that I have in my mind that I learned over the years.

Q. Does cigarette smoking cause emphysema?

MS. CROOKS: I object to the form.

BY MR. CHERVENICK:

A. Again, it goes back to the same kind of question, cause and effect. There are a lot of causes of emphysema and people who smoke may have emphysema, people who don't smoke may have emphysema, so where is the cause in those patients. It's multifactorial, I don't know if it's the cause or it's an associated finding in someone.

Q. Is cigarette smoking a cause of emphysema?

A. Statistically it is associated with emphysema.

Q. Is cigarette smoking the leading cause of emphysema in this country?

A. That would -- that's a good question, but I don't know the answer to your question. I actually don't know the answer to that.

Q. Is cigarette smoking a cause of chronic bronchitis?

A. It's associated with it, yes.

Q. You said associated with it, but I'm asking is it a cause of it?

A. Cause and effect is difficult because, again, you have people who may smoke and may have other causes in their particular health that caused their chronic bronchitis and smoking wasn't the cause and yet they were a smoker, it wasn't the cause and you don't know that as a physician, all you know is you have a patient who is a smoker and the same patient has chronic bronchitis. Is it a cause and effect? Doctors in my profession in internal medicine don't know -- if we don't know cause and effect, we don't call it cause and effect, we just know it's associated. That's why I answered the way I did.
Q. I'm not asking you in any specific person, but in general is cigarette smoking a cause of chronic bronchitis?
A. (Gesturing.)
Q. You don't know?
A. I don't know how to answer your question. I know what you're asking, but it's not the kind of medicine I practice every day. We know

there's an association between the two. Cause and effect is difficult because we see so many things in patients who smoke and don't smoke. It becomes very difficult to know what cause and effect is.
Q. Are you familiar with statistics put out by the Department of Health and Human Services on the percentage of chronic obstructive lung disease that's caused by cigarette smoking?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I couldn't quote it; I might have read it. Again, I'd look at it if you have it.
Q. Are you aware that that office in 1989 stated that 90 percent of chronic obstructive lung disease in the U.S. is caused by cigarette smoking?
A. I wasn't aware of that particular sentence.
Q. Are you aware of a figure of about that percentage?
A. I was not aware of that. I'm aware that the Health and Human Services comes out with those types of statistics, but I didn't know the number. If you asked me a number to pick, I could not have picked.

Q. Is cigarette smoking a cause of heart disease?
A. It's the same question with a different disease at the end of the question. Cigarette smoking and many other factors are involved in heart disease.
Q. Did you know that the Department of Health and Human Services states that one-third of the heart disease in the United States is caused by cigarette smoking?
A. I was not aware of it.
Q. Do you read reports from the Department of Health and Human Services in your practice?
A. Probably not.
Q. Do you read reports of the surgeon general in

your practice?
A. No, I do not. I'm aware of them, but I don't read the report, no.
Q. Are you aware that the surgeon general has stated that cigarette smoking causes lung cancer?
A. Not as much as a physician am I aware of it, as an American I'm aware of it.
Q. Are you aware that cigarette packages state on them that cigarette smoking causes lung cancer?
A. Yes, I'm aware of that.

Q. Are you aware that they state on there that cigarette smoking causes heart disease?
A. I'm -- well, I shouldn't say I'm aware of it, I've not really read a pack of cigarettes, but it wouldn't surprise me is my answer. If you're asking me have I read it and can I swear that I've read it, no, I cannot, I've never really read that.
Q. But you still can't acknowledge that cigarette smoking is a cause of heart disease?
A. That's not my position, that's their position, and they may have their agenda. My job is to take care of patients, and I counsel them like I counsel them on every other aspect of poor health, whether it's lack of exercise, hypercholesterolemia, whatever it is. The only thing we can't change is family history, but we counsel them on everything that they have that may lead to increased risk of any problem.
Q. Does cigarette smoking lead to an increased risk of heart disease?
A. I would say statistically that -- and there are some studies that don't show this by the way, but the majority of time I would say like many risk factors it's listed in the list of risk

factors for development of coronary artery disease, which is what I think you mean by heart disease.
Q. Is cigarette smoking a risk factor for chronic bronchitis?
A. It is one risk factor.
Q. Is it a major risk factor for chronic bronchitis?
A. It would depend on your definition of major.
Q. My definition is more of a risk factor than other factors.

MS. CROOKS: I object to the form.

BY MR. CHERVENICK:
A. Which other factors?
Q. What are the other factors for --
A. Industrial exposure would be high, industrial exposure, work in coal mines, steel mills in the past when people that we still see in our office who worked in the mills before they were cleaned up, those are big factors, a lot of infections in the pre-antibiotic days when they were untreated, we still see a lot of that, hopefully not much in the future.
Q. How about for emphysema, is cigarette smoking a risk factor for the development of emphysema?

A. It's a factor, it's one of the many factors, yes, sure. I mean it's an environmental factor like a lot of things.
Q. When evaluating and treating your patients do you look at whether the person has risk factors related to a particular disease?
A. Yes.
Q. If the risk factor exists, isn't it true that a risk factor needs to be considered in the process of reaching a diagnosis and determining a treatment?
A. Yes.
Q. Do you agree that a person who smokes is at an increased risk for lung cancer?
A. It depends on how much they've smoked.
Q. Let's say they've smoked twenty-pack years.
A. There's a statistically increased risk.
Q. Do you believe that a person who has smoked less than twenty-pack years is not at an increased risk for developing lung cancer?
A. Again, that goes back to our original question. It's not a statistically increased risk by definition, it may be increased over some other population, but there are a lot of factors that go into that.

Q. Does a smoker with a five-pack year history have an increased risk of contracting lung cancer?
A. Increased over what and what type of lung cancer?
Q. Increased over someone who doesn't smoke, any type of lung cancer?
A. Well, not any type. That would not be true.
Q. How about oat cell or small cell?
A. That's the same, oat cell or squamous cell.
Q. Right.
A. Again, I don't know the number and without knowing the number I can't tell you that five-pack years is the year. I mean I really don't know that. Again, it's not something we have learned and something we're taught because we use our statistically significant number of twenty, but to answer five is more than zero or more than four it's not something I know. I've never seen any information to that effect. I just don't know.
Q. Do you know whether a smoker with a five-pack year history has an increased risk of contracting cardiovascular disease?
A. I do not know a number, no.

Q. Does a smoker with a five-pack year history have an increased risk of contracting chronic obstructive pulmonary disease?
A. Same answer, I don't know the number. I don't know the answer to your question.
Q. The medical records that you reviewed in this case it was on two individuals; is that right?
A. That's correct.
Q. And the one was Christa Blankenship; is that correct?

A. That's correct.
Q. Do you have an opinion as to whether or not she's at an increased risk of contracting a smoking-related disease compared to people who have never smoked?
A. I don't have an opinion on that. I'm trying to keep my two ladies separate, hang on. I'll let my answer stand because I'd have to know a specific instance you're asking about or a specific thing.
Q. The same question with respect to Mae Sibo, S-I-B-O, did you review the medical records on her case?
A. Yes.
Q. Do you have an opinion as to whether or not

she's at an increased risk of contracting a smoking-related disease compared to people who have never smoked?
A. It would depend on the disease. Probably in both cases it would depend on the disease, so if you'll ask me specifically, I'll answer your question.
Q. Let's take Blankenship first. What disease do you feel she's at an increased risk of contracting versus people who have never smoked?
A. I don't know that she's increased risk over people who have never smoked, but she's at an increased risk of developing cardiovascular disease, she has hypercholesterolemia and hypertension.
Q. Are those two risk factors for cardiovascular disease?
A. They are.
Q. Is her smoking also a risk factor in the possible or the potential development of cardiovascular disease?
A. Yes.
Q. Is it possible for you to rank those risk factors in terms of her potentially developing

cardiovascular disease?
A. Actually, smoking would be ranked below the other two. Some physicians feel that hypercholesterolemia is the major risk factor in development of cardiovascular disease. Hypertension is a significant risk factor. And studies -- I believe there was a study in West Virginia in maybe '94 or so that actually ranked them in the population that they had and both of those would be above smoking in that population.
Q. Do you believe that Christa Blankenship is at an increased risk of contracting lung cancer versus people who have never smoked?
A. I don't know that she is. There would be a lot of factors in that, and I don't know. I don't know her family history of that.
Q. Let's say she does not have a family history of lung cancer.
A. How many pack years did she smoke, I would have to ask you that?

Q. Many.
A. More than twenty?
Q. Let's say yeah. Let's say she's had more than twenty-pack years.

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A. Then I think if she has a more than a twenty-pack year history of smoking she has a statistically increased risk of developing certain types of lung cancer over the general population.
Q. Is Christa Blankenship at an increased risk of contracting chronic obstructive pulmonary disease over someone who does not smoke?
A. I understand your question. Again, if it's more than twenty-pack years, I would say she is. I didn't see any evidence of that in her file.
Q. Any evidence of --
A. That she had any complaints to that effect. Even if she has more than twenty-pack years as you stated she does I didn't see any complaints to that effect.
Q. Complaints of symptoms that would be symptomatic of chronic obstructive pulmonary disease?
A. I don't recall that. Her complaints as I recall were more in the cardiovascular side of things.
Q. Does she have any other risk factors in your opinion for cardiovascular disease?

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A. She has a mother that died very early of cardiovascular disease, that would be a major risk factor.
Q. So she's got --
A. Hypercholesterolemia, hypertension, family history, again, more than twenty-pack year history of smoking, if you're correct on that, and I think she might be overweight if I recall, she had obesity also. I'm trying to keep the two ladies apart. I think one was thin. I think Mae Sibo was the thinner of the two. I believe she was counseled on weight loss also.
Q. Blankenship was?
A. I think so.
Q. Have you ever met either of these two ladies?
A. No, I have not.
Q. So you've never examined them?
A. Oh, no.
Q. You're just going from your memory on the medical records?
A. Yes.
Q. How about the other woman?
MS. CROOKS: I'll object to the form.
BY MR. CHERVENICK:

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Q. Mae Sibo, does she have any increased risk of contracting lung cancer over someone in the population who has not smoked?
A. What is your recollection of her pack years, could you state that for me?
Q. I can't recall offhand, but let's assume for

purposes of the question it's at least twenty-pack years.
A. If she has more than a twenty-pack year history of smoking, then she would be at an increased risk for development of certain illnesses, certain diseases.
Q. Is lung cancer one of those diseases?
A. Again, I'll emphasize certain types of lung cancer because not all lung cancers would be associated with smoking.
Q. When you say that are you saying that cell types besides squamous cell and small cell are not caused by smoking?
A. Yes. I mean they're not associated with any different numbers in smokers and non-smokers. That's exactly what I'm saying.
Q. If you saw a non-small cell carcinoma in --
A. And non-squamous cell.
Q. Yes, and non-squamous cell --

A. Okay.
Q. -- in someone who had a fifty-pack year smoking history, would you not ascribe the cause to cigarette smoking?
A. I wouldn't know one way or the other, but I wouldn't -- you know, I just wouldn't know.
Q. In that situation that wouldn't exculpate cigarette smoking?
A. It would have no relationship it would seem to me.
Q. It would have no relationship to the cancer?
A. You wouldn't know. Are you talking about the case you talked about, a non-small cell, non-squamous cell carcinoma in a person who smoked, you wouldn't know one way or the other. I mean you wouldn't know even in the other cases of small cell and squamous cell, you really don't know. I mean technically you cannot tell when a person comes in who has lung cancer even if they are a smoker whether that cancer is caused by the smoking. That's something a doctor would not be able to know. That's where you get back to statistical significance, that's all I can say.
Q. But in somebody who has a fifty-pack year

smoking history if it was non-small cell and non-squamous, would you say that it was not caused by cigarette smoking?
A. You wouldn't know.
Q. Okay.
A. You wouldn't say it was not and you wouldn't say that it was, you just wouldn't know. All you know is two things, they have a fifty-pack year history of smoking, they come in with a non-small cell, non-squamous cell carcinoma, you don't know if there's a causal relationship at all, you just don't know if there is or if there isn't.
Q. Let's say somebody presented with a fifty-pack year smoking history and they have a squamous cell carcinoma, would you ascribe the cause to cigarette smoking?

A. I wouldn't because again cause and effect is something doctors don't know. On an individual patient you don't know.
Q. Back to the other plaintiff, Ms. Sibo, does she have an increased risk of contracting chronic obstructive pulmonary disease?
A. In the supposition that she had a greater than twenty-pack year history of smoking she would

have a statistically increased risk of developing chronic obstructive pulmonary disease.
Q. Also on her does she have an increased risk of contracting cardiovascular disease?
A. Again based on the same assumption she would have a statistically increased risk.
Q. Does she have any other risk factors besides smoking for cardiovascular disease?
A. She had a history related to a physician which he documented that she was told once that she had high blood pressure. So that would be a factor if indeed she has high blood pressure. I'm saying that she told a doctor that she had it.
Q. Do you know if she takes any medication to control her high blood pressure?
A. She took medication by history that could have been used for hypertension, Procardia XL was the drug. I don't know because it didn't state in the records whether it was given for hypertension. It could be used for other things. So I don't know if that was the reason it was used. It is an anti-hypertensive in addition to some of its other qualities.

Q. Did you see any of her blood pressure readings in her records?
A. I did.
Q. In your opinion did she have high blood pressure?
A. She did not appear to have it on the records that I saw except for one reading which was borderline elevated, the others were normal. It was the history of it that she had related to a physician.
Q. Can you make a diagnosis of high blood pressure in somebody based on one borderline reading like she had while the others appeared normal?
A. You would not do that.
Q. Does she have any other risk factors for cardiovascular disease other than the possible --
A. Oh, yes, I'm sorry, I was drawing a blank here, she also has hypercholesterolemia, I forgot.
Q. So for her I guess her risk factors for cardiovascular disease would be the smoking and the hyper -- what's the word?
A. Hypercholesterolemia, high cholesterol, high LDL cholesterol.
Q. Do you know if she's on medication to control

her cholesterol?
A. I believe she may be on Lipitor at the present

time.
Q. Do you know whether that has caused a reduction in her cholesterol?
A. I do not know that.
Q. Generally what cholesterol level --
A. Would you mind if I go back to a previous question?
Q. No, ago ahead.
A. On Ms. Sibo as I recall she is also on Propanolol which would be the brand name Inderal. Her blood pressures are generally measured when she's on that medication. What we don't know, you and I don't know is whether she would have had high blood pressure if she were not on the medication. And I also do not know from those records whether she is on that medication because of high blood pressure, it just has her medicines listed on her visits to the doctor, one of which was Propanolol, so she could conceivably have normal blood pressures because of that.
Q. Let me ask you this then, if somebody has normal blood pressure because it's being

controlled by a medication, is that still a risk factor for cardiovascular disease?
A. That particular answer would be no, but it would depend on when they were started on their medication. At the time you are trying to mollify that risk factor by using the medication, of course that's why we treat people. I'm sorry to go back to that, but I remembered after you were on the next question. I didn't mean to interrupt you.
Q. While you're on the medication and it's having an effect, and by effect I mean it's controlling it to an acceptable or normal level, then that is no longer a risk factor for cardiovascular disease?
A. Statistically it would be a much better situation. I'm sorry to interrupt you. I just remembered about the Inderal.
MR. CHERVENICK: Could you read back my question before we started talking about the Inderal?
- - - -
(The record was read back by the Reporter.)
- - - -
BY MR. CHERVENICK:

Q. Generally what cholesterol level is deemed by medical authorities to be a risk factor for cardiovascular disease?
A. The answer would be more in what's called the LDL cholesterol, which is your low density cholesterol. In a person with no history of heart disease to date we try to keep their LDL cholesterol less than 130 for males 45 and older and females 55 and older. We try it in anybody, I'm just saying that's our goal in anyone, but we'll be very strict at that age group. Is that the answer to the question you're asking? It's not so much total

cholesterol anymore.
Q. Well, I know every time I go to the doctor if it's above 200 they tell you to get it below 200 it seems regardless of what the LDL or HDL is. Is that no longer true?
A. Probably not as true as it was several years ago because of the National Cholesterol Education Project information. We mostly use the LDL cholesterol as our goal now.
Q. So you want to see the LDL below --
A. 130.
Q. -- 130? Is there a number above which the

HDL should be?
A. Well, the minimum of HDL is 35, but that's not a very good HDL, that's the minimum of the range. It's fairly complicated, I'll be glad to explain it.
Q. That's okay.
A. I could do it, but it would take some time. That's why they've chosen LDL because it's a simple number that they can publish nationally.
Q. As a general statement if your total cholesterol is let's say 250, but your LDL is below 130, would that person be considered at an increased risk for cardiovascular disease?
A. What's their HDL? See, that's the problem. It would be hard to get an LDL less than 130 with a cholesterol of 250 unless you had an extremely high HDL because it's a formula. An LDL is a calculated value. So to get those numbers you would need a very high HDL.
Q. When you say HDL was a minimum of 35 what do you mean?
A. Well, there is a range on a laboratory report that will say 35 to I think it's in the maybe 69 range, that's what the laboratory prints. So the HDL minimum to be considered in the

normal range would be 35.
Q. Okay.
A. But the relationship between the total cholesterol and the HDL is also a number that's used by many cardiologists as a risk factor. That's why to answer your question it's difficult.
Q. Okay. Do you know what the cholesterol level was in this case in Ms. Sibo?
A. I'd have to look up the actual number, but I recall an LDL level of 180, something in that range. It was fairly above the expected normal -- not the expected normal, I'm sorry, the goal --
Q. The goal of the LDL?
A. Yeah, the goal.
Q. Was that even after she was being treated with the medicine?
A. I did not see a number that I recall after Lipitor therapy. I'm pretty sure that was started more recently.
Q. Does she have any other risk factors that you recall for cardiovascular disease?
A. Ms. Sibo?

Q. Yes, sir.

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A. Well, again, we talked about whether or not she had a history of hypertension. I don't recall even seeing her family history, although it may have been there, I did not see it. She was not obese, and I don't recall ever reading anything about her level of exercise, whether she was a sedentary person or not. Her age would be a risk factor by statistical significance. I think she's 60 some years old, and women over the age of 55 have a statistically increased risk of coronary disease, that's just statistical again, so she has that risk factor.

Q. I want to talk to you about screening or medical monitoring for a little bit. Are you okay?

A. I'll stand up for one second if you don't mind.

Q. That's fine.

A. I just want to stretch. I'm okay, you can ask questions.

Q. This is kind of jumping back into where I was maybe a half an hour ago with Doctor Burns' report, but I want to ask you some questions about medical monitoring.

Do you agree with a proposal to administer a resting electrocardiogram to each

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smoker as of the age of 40 as proposed by Doctor Burns in this case?

MS. CROOKS: I object to the form and also I understand that's not his proposal anymore; is that correct?

MR. CHERVENICK: Well, I think he's blended some things. I'll rephrase the question.

BY MR. CHERVENICK:

Q. Do you believe that administering a resting electrocardiogram to smokers as of the age of 40 is recommended to screen for lung cancer?

A. You didn't mean to say that. Reword that.

Q. To screen for cardiovascular disease, I'm sorry.

A. Okay. I'm sorry to ask you a question back, but are you asking about Doctor Burns' recommendation or do I believe as an internist that getting an electrocardiogram on any 40-year-old to establish a baseline is a good thing to do?

Q. The second one.

A. I believe that people -- you can choose 40 or 45 years of age and we do in our practice. We try to establish a baseline electrocardiogram,

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but smokers and non-smokers are treated alike in that case.

Q. How often do you in your practice administer the EKG to patients? Let's say once you've established the baseline at whatever age, 40 or 45.

A. We do it on a -- it depends. Actually, it depends. It depends on their diseases. For example, someone who has hypertension and I'm

treating their hypertension, if they come in for their yearly physical I'll check an EKG on them. If someone has hypercholesterolemia or any symptoms in the past year or two years, depending on how often they come in, I'll do an EKG on them. So we sort of judge on an individual basis as opposed to an overall rule.

Q. How about generally if a person comes in who is asymptomatic and is just coming in for a yearly physical let's say at the age of 41 and they had an EKG at the age of 40?

A. No, we don't always do that, no. We don't do it if they've had one either. I mean they might bring an EKG from somewhere else. All we want to see is a baseline so we can compare if something changes.

Q. And you said that it makes no difference in your practice whether the person is a smoker or a non-smoker?

A. Yes, I treat them the same. Well, as far as your question which was an EKG, that doesn't make any difference, that's right.

Q. Wouldn't somebody who had the risk factor of say a twenty-pack year smoking history -- why wouldn't you be more inclined to give them an EKG yearly even if they were asymptomatic?

A. That's easy actually. Because that's never been proven to be a good screening technique for coronary artery disease or any other type of disease.

Q. Is there any type of screening technique that you would recommend in somebody who has a twenty-pack year smoking history as a risk factor to screen for cardiovascular disease?

A. I don't recommend any specific test for those people.

Q. Why is that?

A. Well, because no specific test has ever been shown to improve the diagnostic ability of a physician in those cases to predict future coronary events, whether they have a problem at

the present time. The key in my opinion is you get them to quit smoking, that's the one thing you want to do, and you spend a lot of time counseling them, but no test has ever been worthwhile. There's too many false negatives and false positives.

Q. How about a high resolution CT scan to screen smokers for lung cancer?

MS. CROOKS: I object to the form.

BY MR. CHERVENICK:

A. What do you mean about it?

Q. Would you recommend that or do you have a problem doing that as a screening method to detect lung cancer in smokers?

A. Well, I don't do it. You say do I have a problem with it. I mean I don't think it's worthwhile so I don't do it. It's never been shown to me to be worthwhile.

Q. Would you recommend against doing that, a high resolution CT scan in smokers to screen for

tumors?
A. At this time I would, yes.
Q. When you say at this time --
A. Well, patients ask. I've been asked. I was asked just this week actually by a patient who

was a smoker and wanted one, and I explained to him that the test was not a good screening test, that it has been looked at as a possibility of a screening test and there's no evidence to prove -- prove is not a good term, there's no evidence to show that that test is a worthwhile screening test.
Q. In your opinion why is that not a good screening test?
A. Well, there are a couple reasons. First of all, it will pick up a lot of lesions, I'll use the term lesions, that are not malignant, small lesions that you wouldn't pick up with any other screening technique, then you're stuck as a practicing physician as to what you're going to do with that information. Do you sit on it, wait awhile, repeat the scan and get the same information in a few months while the patient worries or do you investigate it?
Investigation of that particular nodule or lesion would be risky, and I don't like to put the patients at that risk because, as you know, our first job is do no harm, and I'm concerned about doing harm to people who are otherwise healthy. So I find that a dangerous thing to

do when you don't have any way to back up the information except with invasive testing.
The second thing --
Q. Is that what's called a false negative?
A. That would be a false positive. Positive means you found something which turns out to be nothing, that's a false positive.
Q. I was using the other example.
A. I understand. A false negative would be if you didn't find something that was there, that's a false negative. If the test looked negative which means normal to us, but there's really something there, that's a false negative.
Q. With a high resolution CT scan I take it the problem that you were just describing is the false positive where it's going to pick up lesions that may not be malignant?
A. That's correct, more so than other screening tests.
Q. Would the administration of a PET scan that can diagnose whether or not that tumor is malignant or lesion is malignant to a high degree of accuracy would that resolve that problem in your mind?
MS. CROOKS: I object to the form.

THE WITNESS: Am I allowed to answer the question?
MS. CROOKS: If you understand it.
BY MR. CHERVENICK:
A. I understand the question, but I don't know the

answer because we don't use PET scans for that purpose.
Q. If a PET scan were to be used for that purpose, in other words a CT is given that picks up a lesion and then a PET scan is done which can as I understand it based on the glucose and the lesion determine whether it's malignant or non-malignant, would that cure that problem of false positives?
MS. CROOKS: I object to the form and to the characterization.
BY MR. CHERVENICK:
Q. Go ahead.
THE WITNESS: Am I supposed to answer the question?
MS. CROOKS: If you can answer it.
BY MR. CHERVENICK:
A. Oh, I can answer it. I don't know the answer. I can answer it because I really don't know. I'm not a radiologist and I really don't -- we

don't use PET scans.
Q. When you say we --
A. Well, I mean the doctors that I'm associated with. I personally have never ordered a PET scan, and I don't know of any patients of mine who have seen other physicians who have had a PET scan. So that's why I can't answer your question.
Q. Are you aware that there are certain institutions such as WVU where the PET scan is utilized routinely after a CT scan?
A. I was not aware of that.
MS. CROOKS: I object to the form. Give me a chance to get the objections in.
THE WITNESS: I'm sorry. I wasn't aware of it. I'm sorry.
BY MR. CHERVENICK:
Q. Were you aware that the physicians at WVU will not operate on somebody who has a lesion showing up on a CT unless a PET scan is first done to determine whether it's malignant?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I wasn't aware of it.
Q. Are you aware of any literature on PET scans

and their diagnostic capabilities as far as malignant versus benign tumors go?
A. Not a specific article.
Q. You said that one of the problems with the CT is the false positive that would result and not knowing what to do with a patient in the interim before you took another CT I guess. Are there any other problems with a CT for screening?
A. Oh, yes.
Q. Can you tell me what those are?
A. Sure. There would still be false negatives, and you wouldn't know that of course at the time you did the test, but there's still false negatives, and there could be a sense of complacency. As I recall your question was in

a smoker; is that correct?
Q. Right.
A. So there would be a sense of complacency if a patient came in and had a false negative, which, of course, again you wouldn't know was a false negative, but it was, and you may have more difficulty getting that person to quit smoking. So I would consider as a practicing physician that that's a difficulty.

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Q. Would that fall under the doctor's role though to counsel that person that just because a CT scan was negative it didn't mean that there was no tumor growing or in the early stages of growing?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. That's what our role is, to get them to quit smoking.
Q. In your opinion would a medical monitoring program be beneficial in any circumstance, not just smoking related, in any circumstance?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. What is your definition of a medical monitoring program?
Q. Any type of screening program where you're using CTs or X-rays or pulmonary function tests in a certain population to determine whether or not a disease is developing in people in the population?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
Q. And not limited to those tests I mentioned, any type of medical diagnostic tests to diagnose a

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problem in a certain population.
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Well, we use mammograms based on the American College of Surgery and the American Cancer Society recommendations. That's something that's been proven to be effective.
Q. Do you agree that before you give that type of screening, that is a mammogram, do you need to show that there's a risk factor present?
A. Well, there is a risk factor present, gender.
Q. Okay. Is that the only risk factor for screening with a mammogram?
A. As far as I know. The age you would start may change, but the American Cancer Society recommends that women of a certain age begin getting mammograms and continue.
Q. What age is that?
A. Generally you get a baseline mammogram between the ages of 35 and 40 with no family history of breast cancer in a first degree relative. You would get a mammogram every other year between the ages of 40 and 50 and yearly after the age of 50.
Q. Do woman over the age of 40 or 50 have to be

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evaluated by their physician before they can

receive a mammogram for breast cancer screening?
A. They do in Pennsylvania.
Q. They have to be evaluated first?
A. They can't just go and get a mammogram, is that what you're asking?
Q. Yes, sir.
A. Oh, no, you have to have a signed prescription or we call it a requisition for a mammogram. You should have a breast exam and a mammogram, it's not just a mammogram.
Q. Do you know whether that position is contradictory to the American Cancer Society's position on mammograms?
A. What position?
Q. That a physician has to examine the woman before she can have a mammogram even if she's over age 40 or 50?
A. I can't answer your question because I don't know. If you have something I could read, I could read it, but my understanding is that's all part of the same screening program.
Q. Okay. Are you familiar with the recommendations for screening teachers and

health care personnel for tuberculosis?
A. I'm familiar that it's done.
Q. You're familiar that such screenings take place in the U.S.?
A. I'm familiar that they take place in Pennsylvania.
Q. That's what I meant.
A. Yes. I don't know about the rest of the country, but I know in Pennsylvania we do it.
Q. Prior to a teacher or a health care worker being screened for tuberculosis should they have a physician evaluate whether they need the screening or not?
A. I think it's required. You say whether they need the screening, I think that is a required test for us to sign their certificate.
Q. Okay. How about are you familiar with recommendations for vision screening for children?
A. I don't know what the recommendations are. I know that children are screened in school for vision, yes.
Q. In your opinion prior to a child being screened for vision should they have a doctor evaluate whether they need to be screened or not?

MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I never thought about that.
Q. Do you have any opinion on that?
A. I think all screening should be in the auspices of a family doctor and that's what we do for a living. We try to work with our patients. I don't do pediatrics, that's why I don't have an opinion on it is what I'm trying to say, but in our field I think all screenings should be in the auspices of a family physician and patient relationship.

Q. But when I say screening I mean for instance in the teacher/health care worker, even if they've not been evaluated by you or someone in your practice but they're a teacher who is coming to get their certificate signed or health care worker, should they be evaluated by a physician and then have a physician determine whether or not they need the TB screening?

MS. CROOKS: I object to the form.

BY MR. CHERVENICK:

A. Again, that's a state requirement. We don't form an opinion on that because that's required, we do see those people. When we do a

TB test in our office we put the test on their arm, we recheck it and the physician sees the patient and signs the form.

Q. With respect to the mammogram do you need to recommend the mammogram in order for the woman to have one even if she's over age 40 or 50?

A. Yes. Well, someone does, some physician does.

Q. Is there any circumstance under which a woman of say age 40 would come to you and you would recommend against a mammogram?

MS. CROOKS: I object to the form, speculative.

BY MR. CHERVENICK:

A. I can't think of any. Follow the guidelines.

Q. And the guidelines are what you just discussed a few minutes ago?

A. Yes.

THE COURT REPORTER: Can we take a break so I can change my paper?

MR. CHERVENICK: Sure.

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(There was a brief pause in the proceedings.)

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BY MR. CHERVENICK:

Q. Doctor, I want to talk a little bit about

monitoring programs or screening programs and these false positives or negatives that we touched on a few minutes ago. Is it your opinion that medical monitoring programs may do more harm than good?

MS. CROOKS: I object to the form.

BY MR. CHERVENICK:

A. I guess they may. They may, sure.

Q. Under what circumstances may they do more harm than good?

A. What type of monitoring program would you be referring to, that would help to answer the question?

Q. Let's say, for instance, CT scans with respect to screen for lung tumors?

A. Well, that's what we talked about earlier, and if you have a false positive, you would increase anxiety in the patient unnecessarily because it's a false positive, you would have to -- you would feel obliged as a physician to evaluate whatever lesion you found on the CT scan and the evaluation itself could be harmful to the patient.

Q. I guess another problem would be that we discussed earlier the false negative where the

test could show no problem whatsoever and the person gets a false sense of security?
A. False negatives are always a problem for physicians. It's even not so much the patient with the false sense of security, but think of it if you're taking care of an individual patient and you get a test that is normal and they have no symptoms, we're talking about a screening test, you're talking about a monitoring program, so a screening test is an asymptomatic person, it's totally different than a person that comes in then with symptoms, the same person comes in two months later and they have some symptoms. Well, even the physicians gets into a false sense of complacency because he knows the test was already done and he believes that the test was okay so we'll have to look somewhere else for some other cause of the symptoms, and that's a danger in medical care, it's a grave danger actually to take care of patients.
Q. How about something like a colonoscopy in people who have a risk factor for colon cancer, is a colonoscopy something that's recognized as an approved screening test for people with

ulcerative colitis?
A. It is a test that's used for screening. The specific recommendations have been changing fairly recently and fairly frequently.
Q. What are the current recommendations?
A. I can't quote for you exactly what they are because I do know they've been changing. I mean certainly there are recommendations and we could look them up, but I don't know what they are specifically.
Q. Well, without getting into the most recent recommendations, is it true that one recommendation for some period of time has been if not yearly, maybe once every couple year colonoscopy to make sure there's no tumor developing in a person's colon?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. What specific type of patient are you referring to?
Q. In someone who has ulcerative colitis.
A. Again, I would like to tell you, but in those cases as a practicing physician what I do is I refer them to a gastroenterologist and let the gastroenterologist who keeps up with that give

them the monitoring program. So I don't know the answer to your question. I wish I could tell you, I cannot.
Q. Okay. Do you know that a gastroenterologist administers periodic colonoscopies to people with ulcerative colitis to screen them to make sure no tumor is developing?
MS. CROOKS: I object to the form.

BY MR. CHERVENICK:
Q. Is that why you refer them to the GI doctor?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Well, generally they're already referred because they have ulcerative colitis. So honestly in practical terms these people are already under the care of a gastrointestinal physician.
Q. Okay. My point is isn't a false negative something that can result in a colonoscopy in a patient like that?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
Q. When you administer a colonoscopy to somebody with ulcerative colitis and it doesn't show a tumor, would that be a false --

A. That would be a false negative.
Q. But even though that false negative can develop and probably usually does develop because not everyone who is given a colonoscopy has colon cancer, colonoscopies are still recommended in those individuals, aren't they?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I have to ask to have the question repeated, I'm sorry. It got complicated and it seems like you changed some things.
Q. Even though false negatives develop when administering colonoscopies to people with risk factors for colon cancer, colonoscopies are still recommended for people with those risk factors, aren't they?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I don't know what the recommendation is, so I can't answer your question honestly. You would have to ask a gastroenterologist that question.
Q. You don't know whether colonoscopies are administered to people with risk factors for colon cancer?
A. That wasn't the question.

MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
Q. Do you know whether colonoscopies are administered to people with risk factors for colon cancer?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Yes, I know that they are.
Q. And they're administered even though false negatives occur when those tests are administered, aren't they?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Yes.
Q. Do you know how the false negatives are dealt with by the gastroenterologists in those cases?
A. I don't know how you could deal with false negatives other than the danger that they pose.
Q. Could one way be explain to the person that

they still need a repeat one done in a year or within two years, something like that, would that be one way to deal with a false negative in that circumstance?

MS. CROOKS: I object to the form.

BY MR. CHERVENICK:

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A. Not in that circumstance.
Q. Why not?
A. Because in the circumstance that you chose, which is a periodic screening for a particular disease, the periodicity is already set so a false negative wouldn't change the periodicity.
Q. What do you mean when you say it wouldn't change the periodicity?
A. This is an if because I told you earlier I don't know what the actual recommendations are at the present time.
Q. Right.
A. If the test is to be performed every three years, then if you have a false negative, you would perform the test in three years, it wouldn't change. Your earlier question was would you tell the patient to come back in one or two years, and the answer is no because you wouldn't have any reason to tell them that since the test was done to screen for something that again using your assumption was there, but not found, therefore, it wouldn't change the periodicity, you would still do it at the time it was then due again, much to the detriment of the patient might I add.

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Q. I think I confused you because I had thrown in there one to three years. Assuming let's say it's to be done every three years and the person goes in today and it's negative, no tumor, I'll change my question to be doesn't the physician get around that false negative by telling that patient you still have to come back for the test three years down the road because it doesn't mean something won't develop between now and then?
A. That has nothing to do with a false negative. That's the periodicity of the test, that has nothing to do with a false negative.
Q. Okay. So that's the periodicity of the test. How about in a screening situation for lung cancer, couldn't you set it up so that the CT scan was performed at say one-year intervals regardless of whether a tumor showed up on the CT scan, would that take care of the false negative program?

MS. CROOKS: I object to the form.

BY MR. CHERVENICK:

Q. So that even if the test was negative the person still had to come back within a year, same as the colon cancer situation?

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A. It's not the same.
Q. Why isn't that the same?
A. Because colon cancer screening has been established as a reasonable screening technique

to find a problem and hopefully change the outcome. Lung cancer screening has never been established to be able to find a problem and change the outcome and, therefore, it isn't recommended at the present time.
Q. Okay. I'm talking just about the false negative situation though, wouldn't a periodic examination every year, every six months, every two years, whatever the period is, wouldn't that change the problem of the false negative regardless of whether or not it's affected in the long run? I'm just dealing with the false negative aspect.
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
Q. Would you agree with me that if you did it on a periodic basis it would solve the false negative problem?
A. No.
Q. Why not?
A. It doesn't solve it in the previous instance

either of a colonoscopy. Your original question as I recall was would the periodicity change -- I know you didn't ask that, but I answered it I thought the periodicity wouldn't change on a false negative. False negatives aren't solved by frequent testing unless the testing is so frequent as to be repeated in some, you know, amount of time that would be unreasonable for patient's good health because now you're entering into complications of tests unrelated to the outcome. False negatives are a danger and the periodicity doesn't change that, that becomes a danger in any test.
Q. Why would it be a danger -- let's take the colonoscopy instance first. Why would it be a danger in that if it's going to be done every couple years anyway?
A. It's not done that often first of all. So to be fair it isn't done that frequently. The danger is that you think you thoroughly examined the patient, you performed a test that was approved and done appropriately, but it just was a false negative, okay. Now a patient comes in with symptoms, because, again, we were dealing with asymptomatic people in the

beginning who were getting a test as recommended by in this case the American Cancer Society and American College of Surgeons. Now the patient comes in to see you and they have one symptom or another, be that weight loss, rectal bleeding, abdominal discomfort, and you assume -- one assumes, okay, patient and physician alike that that test has already been evaluated so that shouldn't be the problem. That's the danger of the false negatives even in a screening program, you already think that you've checked that particular organ system and there could still be a problem there.
Q. When you're saying that there's a problem with a false negative you're talking about not just

on the patient's part, but on the physician's part as well?
A. Absolutely, yes.
Q. Wouldn't the physician be aware that a tumor could have grown in the interim from whenever the last colonoscopy was taken, it just didn't show up when the colonoscopy was done and therefore this could be a tumor and the person needs to be evaluated?
MS. CROOKS: I object to the form.

BY MR. CHERVENICK:
A. Physicians are always aware of the possibilities. That isn't difficult for us. What's difficult is knowing what the possibilities are and then finding the appropriate test to evaluate the patient and not harm the patient in the process. We face that problem every day.
Q. Okay. In that colonoscopy situation wouldn't it be prudent just to give the person another colonoscopy at that point to see if a tumor had developed in the interim?
A. That's a question you'd answer in hindsight unfortunately because I know what it's like in real life and when you have a test that you've already performed and you feel confident in your ability as a physician and even though you know the possibility exists, it wouldn't be the first thing on your list of working up that patient for their particular symptom because, remember, they were asymptomatic to begin with and you did the test and it was a false negative, you just didn't know it was a false negative.
Q. And this is even in a person with a risk factor

for colon cancer that we're talking about; right?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. What risk factor would that be?
Q. Ulcerative colitis or family history.
A. Again, it would depend what the risk factor is because they would have different presentations.
Q. But my point is if they've got a risk factor and they're now showing up with bleeding or loss of weight or whatever, wouldn't the physician who had been treating that person all along be inclined to administer another colonoscopy?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Are you asking for my opinion as an internist?
Q. Yes.
A. It becomes a very difficult situation. I think that eventually a colonoscopy would be repeated, eventually, but a false negative does lead a patient and physician to -- and even the patient may not present right away because they feel they're okay because their test was

negative, that's the other danger. When they finally show up the physician says, well, let me see what was done, you look at the test, you say, well, you had a colonoscopy, you know, let's see what else it could be, and eventually I think in practicing medicine you would come back around to doing that test, but the delay could be, you know, bad for the patient.
Q. Let me move off of that example then to a CT scan let's say in a smoker, a CT scan is taken, there's no lesion, nine months later the person presents and is coughing up blood and has lost a significant amount of weight, would you as a physician do another CT scan at that point even though nine months previous it had showed nothing?
A. Well, the situations are not equivalent because colon cancer screening is an established screening program, lung cancer screening is not.
Q. I understand. If we can put that aside just for the purposes of that question, wouldn't you as a physician be inclined to get a chest X-ray or a CT scan at that point if the person is now symptomatic?

MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. In a person who came into my office coughing up blood?
Q. Yes, sir.
A. You would do a chest X-ray and probably you may go on to bronchoscopy, may or may not depending on the patient and what you knew, may or may not repeat the CT scan first. It depends on the pulmonary physician consult too. I don't do bronchoscopies, I would refer a patient to a pulmonary physician, he may choose a bronchoscopy prior to a repeat CT scan.
Q. Wouldn't the normal practice be to do a repeat chest X-ray before doing a bronchoscopy?
A. Yes. You would not ignore a patient who is coughing up blood.
Q. That would be even though a CT or chest X-ray was done nine months before and was clean?
A. Hopefully it wouldn't have been done unnecessarily and it's not been established that that is a necessary test at this point.
Q. Have you ever recommended X-rays to asymptomatic smokers, chest X-rays?
MS. CROOKS: I object to the form.

BY MR. CHERVENICK:
A. I've never recommended chest X-rays to smokers as opposed to non-smokers, that answer is true. In the past -- I've been in practice for 23 years, in the past we did chest X-rays as part of a physical examination, we didn't distinguish between smokers and non-smokers, we no longer do that, that's no longer a recommendation. Is that the answer to your question?
Q. Well, I'm trying to decipher that in my mind.

A. Go ahead. In other words, I never distinguish between smokers and non-smokers, so if you ask me if I ever recommended a chest X-ray to a patient, the answer is yes. Was it because they were a smoker, the answer is no.
Q. So you've never recommended a chest X-ray to somebody who is a smoker because they're a smoker?
A. That's correct.
MS. CROOKS: I object to the form.
MR. CHERVENICK: That's the only thing he's agreed with all day.
MS. CROOKS: Asymptomatic, correct, is that what you meant?

BY MR. CHERVENICK:
A. I assumed you meant just because they were smokers.
Q. Right.
THE WITNESS: I thought I knew, I'm sorry. I thought he meant asymptomatic.
MS. CROOKS: I thought he did too, but I needed to be sure.
THE WITNESS: I understand.
BY MR. CHERVENICK:
Q. That's what I meant. I'm not trying to trick you or anything. That's what I meant.
I'll just ask this then to close the door on that issue, have you ever recommended an X-ray for an asymptomatic smoker because he was a smoker?
A. I have not.
Q. I think you indicated about a week ago you had a patient come into your office and request a CT scan because he had been a smoker and he was asymptomatic and you had declined that request?
A. That's correct.
Q. Do you take CT scans or have them performed in your office?
A. No.

MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. We don't do CT scans in our office.
Q. Do you have any training in interpreting CT scans?
A. No.
Q. Do you in any way assist others in interpreting CT scans that you have taken of your patients?
A. No.
Q. Do you know what percentage of the diagnosed lung cancers in the United States last year were operable?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I do not. It would depend on the type of lung cancer I'm sure.
Q. If I broke it down into cell types, would you know the answer?
A. I would know which ones are more operable than others, but I would not know the percentages.
Q. Which ones are more operable than others?
MS. CROOKS: I object to the form.

BY MR. CHERVENICK:
A. Adenocarcinomas would be more operable than others, small cell carcinomas would not be

operable, we do not operate on small cell carcinomas.
Q. Why are adenocarcinomas more operable than the other cell cancers?
A. It has to do with cell growth characteristics. You can find adenocarcinomas that are still able to be removed prior to metastases, spread, I'm sorry. That would be the reason why.
Q. The adenocarcinoma is more -- just so I understand it, the adenocarcinoma is more likely to have not spread, is that why?
A. That's my understanding.
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
Q. I'm going to change the question just a little bit and use the word resectable instead of operable.
A. That's a better word actually because you can operate on anything.
Q. Let me ask you this then, I just didn't want you to think it was the same question and I was wasting your time.
A. Okay.
Q. Do you know what percentage of diagnosed lung cancers in the United States last year were

resectable?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. See, I wouldn't know -- again, what's your definition of resectable, but after you tell me the definition I still wouldn't know the percentage. I still wouldn't know.
Q. Is it true that the only curative treatment for lung cancer is resection at an early stage of the disease?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I don't know.
Q. In your opinion can early detection of lung cancer and resection extend the patient's life?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. In my opinion?
Q. Yes, sir.
A. No, but, again, it depends on the type of lung cancer. They're not all the same.
Q. In your opinion is an adenocarcinoma caused by cigarette smoking?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:

A. Again, cause and effect here like we talked about earlier today, you will find adenocarcinomas in non-smokers as well as smokers. So cause and effect I have no idea.
Q. In your opinion can the early detection of an adenocarcinoma in the lung and resection extend the patient's life?

MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I don't know about extending the patient's life.
Q. Are you questioning that or are you just saying that you don't know the answer?
A. I don't know. I don't know the actual numbers that you might be looking for that you may know that I don't know. The problem with these type of questions for a general internist is that when we find a lesion on a chest X-ray in a symptomatic person, because that's how we would find them of course, or if they had an X-ray done preoperatively because the surgeon or the hospital required it, we would refer that person to an oncologist. That's why I don't really know the answer to some of these questions because we don't actually sit with

our patients and counsel them on specific therapeutic options, we let the oncologist do that. We just don't do it as much in our practice because we have good oncologists here.
Q. Okay. In general are cure rates for lung cancer different for different stages of diagnosis?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. What's your definition of cure?
Q. I was going to ask you that. How do you define cure in a cancer situation?
A. Well, there's more than one way to define cure. Some journal articles will use a five-year cure rate, which just means that at five years you have no evidence of a tumor, that's a five-year cure rate.
Q. Okay.
A. I'd like to think as a doctor who takes care of patients on a daily basis that a cure is what a lay person thinks of as a cure and that is that they're going to live long enough to be hit by a truck instead of die of that tumor.
Q. Okay. Is there any definition that you use in your practice?

A. My initial answer to that would be no unless it's the latter definition and that is a cure to me is a cure that means that there is no evidence of that disease for the rest of that person's life and they die of natural causes as the lay person would call it or some other disease. You're talking about of cancer; right?
Q. Right.
A. That they would not ever get that cancer back again.
Q. Is it fair to say that in the medical profession there are different definitions of cure for those different types of situations, i.e., there's a one-year cure rate, there's a five-year cure rate and then there's the definition that you're using a lay person --
A. Sure.

MS. CROOKS: Let me object to the form.
BY MR. CHERVENICK:
A. Object to the form, but you could have different definitions in law or medicine.
Q. Using your definition, which I'm going to say is the layman's definition, of cure are there

different cure rates for lung cancer based on the different stages of when a tumor is diagnosed?
A. My understanding is there is not, but, again, you're lumping all lung cancers and you're saying a Stage I no matter what the cell type is, a Stage II no matter what the cell type is. My understanding is even if you do that there probably is no difference in my definition of cure rate which means that you die of something else.
Q. If I throw the cell type in there let's say for an adenocarcinoma, is there a difference in the cure rate whether it's diagnosed at Stage I versus Stage III?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. In my definition of cure rate I don't think there's any difference.
Q. How about in the five-year cure rate?
A. That would be something you'd have to ask an oncologist because we don't deal with those type of numbers in our practice.
Q. How about for squamous cell lung cancer, is there a difference between -- a difference in

the cure rate between a Stage I and a Stage III or later when it's initially diagnosed?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Are you talking about mortality? Do you mean my definition of cure rate?
Q. Right, let's start with your definition.
A. I don't believe there's any difference in the stage in overall mortality.
Q. Regardless of the cell type, is that what you're saying?
A. That's what I'm saying, although I'd have to look up the statistics to be sure, that's correct. In other words, the mortality -- with my definition of cure rate the mortality is going to be the same regardless of the stage at which a tumor is picked up.
Q. Is that for any cell type?
A. I can't answer specifically for things such as mesothelioma which is a fairly rare tumor, a sarcoma in the lung, we're not talking about those things, so that may be different, but I don't follow those statistics and we don't see much of that.
Q. Let's stick to oat cells, squamous cell,

adenocarcinoma.
A. That's the same question that I answered and that is that the stage at which the tumor is

discovered does not influence the overall mortality.
Q. How about the five-year cure rate, does it have any influence on the five-year cure rate?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I don't know the answer to your question.
Q. Do you believe that diagnosing a tumor at a Stage I has an effect on the survival rate of that cancer over a Stage III or higher?
A. What's your definition of survival rate?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
Q. Let's say a five-year survival rate.
A. Hang on. You asked me --
Q. Well, let's just strike that, let me ask you something else.
A. Okay.
Q. If I use the term survival rate, does that have a different meaning to you than cure rate?
A. It does to me.
Q. What's the difference?

A. Cure rate to me is what I already mentioned and that is that you never get that cancer again and die of another cause. Survival rate would be your time from the time of diagnosis to the time of death, mortality from that particular tumor.
Q. Let me go ahead and ask the question.
A. Okay.
Q. Does diagnosing a lung cancer at Stage I versus Stage III or later have an effect on the survival rate of that cancer?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. The survival time -- you're using the term rate, time because you found it earlier they die at the same time, but their time from diagnosis to death would be different because you discovered the tumor earlier.
Q. So you're saying it has no effect on the length other than the fact that it was just discovered earlier?
A. That's correct.
Q. Is that for all cell types of lung cancer --
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:

Q. -- putting aside the mesotheliomas?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I understand. She got it. My understanding is that's the case. An oncologist could answer better, but I'm fairly certain that that's the case.
Q. Is there no extension in a person's life if a lung tumor is diagnosed at Stage I or Stage III or later?
A. Based on what you said earlier --
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. -- with your definition of -- I'm sorry, I

meant to say oat cell carcinoma and squamous cell carcinoma there would be no difference overall in the time of their death, it would just be that you found it earlier. Did that answer your question?
Q. Yes.
A. Okay.
Q. So even if it's diagnosed in Stage I are you saying it doesn't make any difference on the length of the person's life?
A. That's correct.

Q. Why then do physicians try to diagnose a lung tumor at an early stage and resect it?
A. Well, you're assuming that they do that. You have to tell me exactly how they're doing that.
Q. Well, let's say this, why do physicians operate to resect lung tumors that they have determined have not yet spread to other organs?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Well, I'm not the physician who does the surgery and I'm not the oncologist, okay. As an internist I would wonder that myself.
Q. Okay. And you would wonder that because in your opinion there's no benefit from resecting that tumor that has not yet spread?
A. There's no medical benefit. There's no mortality benefit. I shouldn't have used the word medical, it's not a good word. The benefit is often, and we face this with our patients, you have a patient who has a new diagnosis of a tumor, in this case you're referring to lung, it's difficult at that time regardless of the amount of counseling to convince that person that you're not going to do anything to try to help them.

Q. Okay. You used the term mortality benefit, could you explain to me what you mean or how you define that?
A. The same thing as your survival that you used earlier, that is that from the time of the diagnosis until the time that that person is going to die, whatever that time is, you will not affect that by doing a surgical procedure.
Q. Okay. But nonetheless and notwithstanding that if somebody comes to your office and let's say they're coughing up blood and you have a chest X-ray taken and you see a shadow on the X-ray that looks suspicious for a tumor, you refer that person to a pulmonary physician I take it?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. Not immediately.
Q. What would you do?
A. On that person?
Q. Yes, sir.
A. Did you already do the chest X-ray?
Q. Yes, you did the chest X-ray and it --
A. Generally what will happen is on a chest X-ray report that we will get the recommendation on the bottom of the report will be get a CT scan

for further evaluation.
Q. Okay.
A. So we would generally proceed with that and in my case generally I would proceed with that and do the referral at the same time. The reason being you do not have a cell type if indeed that is a tumor. So you wouldn't always go right away -- your question was would I refer to the pulmonary physician, the answer is possibly not because we might be able to make that diagnosis without a pulmonary physician's involvement, it could be an oncologist is what I'm saying. To try to answer specifically it depends on what I knew in any given case.
Q. That was a bad question. I should have said under the circumstances that we discussed a person is coughing up blood, you get a chest X-ray, you see a shadow that looks suspicious for a lesion, the question should be would that person be referred by you to another specialist?
A. Eventually probably, not just at that point is what my answer is.
Q. What further would you do at that point?
A. Again, the X-ray report with the lesion in this

day in age would almost always say get a CT scan for further evaluation. We would tell the patient that something showed on their chest X-ray, it may be nothing, but they can get a CT scan for further evaluation, they would then proceed to get the CT scan. Depending on my report on the CT scan the next step would be taken.
Q. Let's say the CT scan confirmed that it was a lesion of some sort in the lung.
A. Then the report on the CT scan would determine what I do because if the CT scan said to me as their physician we can reach this with a needle biopsy in the radiologic department, then I would proceed in that direction first.
Q. Do you do needle biopsies at your office?
A. No.
Q. That would be --
A. It's done under CT guidance.
Q. Okay. Radiologists would do that?
A. That's correct.
Q. So if a radiologist can do a needle biopsy, that would be done. If it's not in a location where a needle biopsy could be done and a bronchoscopy needs to be done, I assume you

refer to a pulmonary physician?
A. That's how it's done, yes.
Q. And then either the radiologist or the -- I guess the radiologist takes the needle biopsy, gives it to the pathology lab or pathology department who then does the staining and makes a determination if it's a malignant tumor versus something else; is that correct?
A. If possible, yes.
Q. And at that point the person is referred to an

oncologist?
A. If the diagnosis of a malignancy is made, yes.
Q. Now, in your opinion is all of that unnecessary, that means the repeat -- not the repeat, but the CT scan after the X-ray and the needle biopsy or the bronchoscopy and the referral to the oncologist, is all of that unnecessary in terms of the person's mortality?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. That's a question that has too many ifs. You have to certainly evaluate what you found, none of that is unnecessary.
Q. Well, let's say eventually it has become a malignant tumor and the person is then referred

to an oncologist for treatment, is in your opinion all those -- were all those unnecessary because whether it was malignant or not malignant -- strike that, that's a bad question. Is all that unnecessary because even if it was malignant and it turned out to be malignant, resection is not going to make any difference in the patient's mortality anyway?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. No.
Q. Why is that?
A. Because you're assuming resection, which I'm not assuming, and you don't know as an internist what else might be available to this person that the oncologist might know that you might not know. So we would always refer in our field to a specialist in that field.
Q. Is there any treatment for lung cancer -- we've discussed resection, so I'm talking other than resection, is there any treatment for lung cancer that has been shown to increase somebody's mortality?
A. You didn't mean that.
MS. CROOKS: Maybe he does, tell him.

BY MR. CHERVENICK:
A. Yes, anything unnecessary would increase their mortality.
Q. Is there any treatment that lengthens a person's life after the diagnosis?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I understand your question, do not know the answer that an oncologist might know.
Q. Okay. Do you know whether there are any treatment modalities for lung cancer that have proven to be effective as resection in terms of treatment for lung cancer?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. It depends on your definition of lung cancer here.
Q. Let's stick to squamous cell, oat cell and adenocarcinoma.
A. You can't do that. Oat cell is not resectable.
Q. Okay.

A. You don't resect an oat cell cancer because an oat cell cancer from my understanding by definition has already spread by the time you find it. So resection of a primary tumor, an

oat cell, would not prevent anything, so we don't resect oat cells.
Q. Okay.
A. That would be chemotherapy.
Q. How about the same question for the squamous and the adenocarcinoma, are there any treatment modalities that have been proven to lengthen a person's life?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. I'm going to answer this way that not being an oncologist there are protocols that are being used all the time and that's why we refer. They may be trying new protocols, you know, you could call it experimental if you'd like, but new protocols of treatment are being used all the time. My understanding is that so far nothing has proven more effective than others so we let them make that decision, I do not make that decision, and I don't know the answer of what the latest protocol is because I don't keep track of that.
Q. Okay. If there are treatment protocols that oncologists are using that are proving effective against lung cancers, would it be

important to diagnose the lung tumors early before they've spread to other organs in the body?
MS. CROOKS: I object to the form.
BY MR. CHERVENICK:
A. That's an if question that I don't know the answer to.
MR. CHERVENICK: I think those are all the questions I have, Doctor.
MS. CROOKS: I have no questions.
THE COURT REPORTER: Do you need this expedited?
MR. CHERVENICK: By Wednesday would be fine.
MS. CROOKS: You can mail mine Wednesday overnight.
- - - -
(The proceedings were concluded at 5:34 p.m.)
- - - -

COMMONWEALTH OF PENNSYLVANIA) CERTIFICATE
COUNTY OF ALLEGHENY) SS:
I, Beth E. Welsh, a Court Reporter and Notary Public in and for the Commonwealth of Pennsylvania, do hereby certify that the witness, GEORGE ALAN YEASTED, M.D. was by me first duly sworn to testify

to the truth; that the foregoing deposition was taken at the time and place stated herein; and that the said deposition was recorded stenographically by me and then reduced to printing under my direction, and constitutes a true record of the testimony given by said witness.

I further certify that the inspection, reading and signing of said deposition were NOT waived by counsel for the respective parties and by the witness.

I further certify that I am not a relative or employee of any of the parties, or a relative or employee of either counsel, and that I am in no way interested directly or indirectly in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office this 12th day of September, 2000.

_____

Notary Public

COMMONWEALTH OF PENNSYLVANIA)
COUNTY OF ALLEGHENY)

E R R A T A
S H E E T

I, GEORGE ALAN YEASTED, M.D., have read the foregoing pages of my deposition given on Thursday, September 7, 2000, and wish to make the following, if any, amendments, additions, deletions or corrections:

Pg. No.	Line No.	Change and reason for change:

In all other respects, the transcript is true and correct.

_____

GEORGE ALAN YEASTED, M.D.

Subscribed and sworn to before me this _____ day of _____, 2000.

_____

Notary Public

AKF Reference No. BW61025

AKF REPORTERS, INC.
AKF Building
436 Boulevard of the Allies
Pittsburgh, PA 15219
(412) 261-2323

September 12, 2000

TO: Susan Davis Crooks, Esq.
Stephanie T. Perry, Ph.D., Esq.
WOMBLE CARLYLE SANDRIDGE & RICE
Suite 2100

150 Fayetteville Street Mall
Post Office Box 831
Raleigh, NC 27602

RE: DEPOSITION OF GEORGE ALAN YEASTED, M.D.
NOTICE OF NON-WAIVER OF SIGNATURE

Please have the deponent read his deposition transcript. All corrections are to be noted on the preceding Errata Sheet.

Upon completion of the above, the Deponent must affix his signature on the Errata Sheet, and it is to then be notarized.

Please forward the signed original of the Errata Sheet to David P. Chervenick, Esq. for attachment to the original transcript, which is in his possession. Send a copy of same to all counsel, and also a copy to me.

Please return the completed Errata Sheet within thirty (30) days of receipt hereof.

Beth E. Welsh
Court Reporter

cc: David P. Chervenick, Esq.
Mary Jo Middelhoff, Esq.
Meredith Perkins, Esq.
Corey Palumbo, Esq.